the contemporary phenomenology and empirical understanding of this and other dissociative conditions. The failure to detect dissociative disorders represents an important clinical issue for mental health care in Northern Ireland, and by extension the Republic of Ireland, as a recent study has found that dissociative disorders, including DID, are not uncommon in complex psychiatric patients in the Province.[12] Partly because of the failure to accurately detect dissociative disorders, and as a consequence engage in effective treatments, individuals with these conditions often have large case files, multiple inpatient hospital admissions, and represent a considerable burden on mental health resources. Treatment strategies for dissociative disorders are relatively distinct from many other psychiatric conditions, and usually involve a phase-oriented psychotherapy approach, similar to the treatment for complex PTSD. Thus the accurate detection of these conditions is the first step to effective treatment.

We appreciate that 'psychiatric folklore' has tended to deem dissociative disorders as rare, and with the absence of valid scientific data before the early 1980s this perception was in line with the empirical knowledge of that time. However, with the exception of dissociative fugue, which still appears to be rare, contemporary studies indicate that dissociative disorders are not uncommon in psychiatric settings. For example, prevalence rate studies from around the world have reported dissociative disorders in over 1% of the psychiatric in-patient population.[13-16]

In our opinion, the inclusion of phenomenological and treatment information on dissociation and dissociative disorders, in what we know is already a very full training curriculum for clinical psychologist and psychiatrists, is worthy of serious consideration.

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ADHD

Re*: Attention Deficit Hyperactivity Disorder versus Childhood Bipolar Disorder.*

In the United States there has been a massive increase in the diagnosis of bipolar disorder in children in certain areas. This can be seen in the paper on the *Risk of Substance Use Disorders in Adolescents with bipolar disorder* by Wilens *et al.*[1] I started working in child psychiatry in 1974. Since that time I have seen two people with bipolar disorder in the age ranges described by this paper. I find the 'Boston' view of bipolar disorders does not gel with clinical reality. I guess the view of not gelling with clinical reality is easily dismissed. The overlap in symptoms of ADHD and bipolar disorder appears to be what has caused the problem. Would the same result have been found if it was done in New Orleans or London? I don't know what to make of bipolar populations selected as they were selected through newspaper advertisements, internet postings, etc. I would be much happier with a diagnosis of dysphoric conduct disorder than childhood bipolar disorder with conduct disorder. In addition mood stabilisers don't work well in these patients in my experience.

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